OAH 84-0900-30708

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF HEALTH

In the Matter of Fairview University Transitional Services, Minneapolis (IIDR)

RECOMMENDED DECISION

This matter came before Administrative Law Judge Tammy L. Pust for an independent informal dispute resolution meeting ("IIDR") on August 27, 2013. The IIDR concluded on that date.

Christine R. Campbell, a Registered Nurse ("RN") and Nurse Evaluator, appeared on behalf of the Minnesota Department of Health ("the Department"). The following individuals also participated in the IIDR on behalf of the Department: Mary Cahill, Planner Principal with the Department's Division of Compliance Monitoring; Rita Lucking, RN Investigator ("Surveyor") with the Department's Office of Health Facility Complaints ("OHFC"); and Kristine Lohrke, Assistant Director of the OHFC and Supervisor of the Surveyor.

Samuel D. Orbovich and Katherine B. Ilten, Fredrikson & Byron, P.A., appeared on behalf of Fairview University Transitional Services ("Fairview TCU" or "the facility"). The following persons also attended the IIDR and made comments on behalf of the facility: [Director] of the Fairview TCU; [Physician A], Fairview TCU Medical Director; [Nurse B], Nurse Manager at the facility; and [Nurse C], RN and MDS Coordinator at the facility.[1]

STATEMENT OF THE ISSUES

Based on the exhibits and arguments made at the IIDR and for the reasons set forth in the Memorandum which follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

1. The deficiency identified in F-Tag 224 is not supported by the evidence and should be dismissed in favor of a finding of no deficient practice.

[1] Pursuant to Minn. Stat. § 13.03, subd. 8a, individuals who are not owners of the skilled nursing facility have been omitted to protect their privacy.

2. The deficiency identified in F-Tag 309 is supported in full, with no deletion of findings and no change in the assigned scope or severity.

Dated: September 11, 2013

s/Tammy L. Pust
TAMMY L. PUST
Administrative Law Judge

Reported: Digitally Recorded
No transcript prepared

NOTICE

Pursuant to Minn. Stat. § 144A.10, subdivision 16(d)(6), this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

MEMORANDUM

This matter arises out of an abbreviated standard state compliance survey conducted at Fairview University Transitional Services on March 29, 2013.[2] Pursuant to the IIDR process set forth in Minn. Stat. § 144A.10, subd. 16, Fairview TCU challenges the Surveyor's identification of two alleged deficiencies related to its care of one resident ("the Resident").[3]

Background

Following an investigation stemming from the facility's self-report related to a death potentially linked to an alleged medication omission,[4] the Department issued a Statement of Deficiencies[5] in which it identified that the facility had failed to meet federal regulatory requirements for participation in the Medicare and Medicaid programs in two specific respects:

[2] Exhibit (Ex.) E-1.
[3] The resident's name has been omitted as a privacy safeguard.
[4] Fairview University Transitional Services Survey Exit: March 29, 2013, at p. 2, provided by the Department in its three-ring binder of exhibits, before Ex. A.
[5] Ex. E.

1. F-Tag[6] 224: Failure to comply with 42 C.F.R. § 483.13(c), which provides as follows:

   Staff Treatment of Residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

2. F-Tag 309: Failure to comply with 42 C.F.R. § 483.25, which provides as follows:

   Quality of Care. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Relying upon the U.S. Department of Health & Human Services' Centers for Medicare and & Medicaid Services' ("CMS") Scope and Severity Grid,[7] the Department assigned each of the two deficiency tags a seriousness level of "G."[8] As of the date of the IIDR, no monetary sanction had been imposed against the facility as a result of the cited deficiencies.[9]

A regulated facility is subject to remedial action if it is not in "substantial compliance" with one or more regulatory standards.[10] A facility is not in substantial compliance if there is a deficiency that creates at least the "potential for more than minimal harm" to one or more residents.[11] Such harms result in a rating of "D" or above on the CMS Grid. Upon a finding of a lack of substantial compliance, CMS may require the facility to correct the deficiencies pursuant to a correction plan and impose other sanctions, including decertification from the Medicare and Medicaid programs.[12]

[6] Deficiency findings are noted in a Statement of Deficiencies under numbered "tags." Each tag corresponds to a specific regulatory requirement.
[7] The CMS Grid is a three-column, four-level matrix that provides 12 alphabetically designated ("A" through "G") categories used by compliance surveyors to rate, for each identified deficiency tag, both the severity of possible or actual harm and the scope of those actually or potentially harmed.
[8] On the CMS Grid, a "G" designation indicates that a cited deficiency presented "actual harm that is not immediate jeopardy" in an "isolated" scope.
[9] See, Fairview University Transitional Services's [sic] Memorandum in Support of IIDR, p. 1, n. 1.
[10] 42 C.F.R. § 488.400.
[11] 42 C.F.R. § 488.301.
[12] 42 C.F.R. §§ 488.402, 488.406, 488.408, 488.412 and 488.440.

The Resident's Treatment

The Resident was a 73-year-old man with a history of bladder cancer. He was admitted to the University of Minnesota Medical Center, Fairview[13] ("Hospital"), where he underwent surgery, a cystectomy with ileal conduit creation, on December 11, 2012. While still hospitalized, the Resident experienced post-operative complications and underwent a second surgical procedure, a turnbull loop ileostomy, on December 13, 2012. He was discharged to his home on December 18, 2012.[14] Relevant to the present matter, the Resident was not prescribed an anti-coagulant medication ("Heparin") by the Hospital's discharging physician.[15]

Eight days later, the Resident was again admitted to the Hospital and underwent another procedure, a necrosectomy with placement of a wound VAC. Following Occupational Therapy ("OT") and Physical Therapy ("PT") consultations during his Hospital stay, the Resident was discharged to the Fairview TCU on January 2, 2013 "given [his] continued nursing care and wound care needs, and continued need for PT/OT."[16] He was not prescribed Heparin upon his discharge.[17]

Upon the Resident's admission to the facility, on January 2, 2013 a Physician Assistant[18] ("Physician Assistant") issued various orders with respect to his care. In relevant part, the Physician Assistant ordered both OT and PT consultations for the Resident, and further ordered the facility's nursing staff to "apply pneumatic compression device (PCD) – Bilateral calf."[19] The Resident was also prescribed and provided a 325 mg dose of aspirin on a daily basis.[20]

A compression device is used to prevent deep vein thrombosis ("DVT").[21] DVT constitutes the formation of blood clots in the vein(s), often but not exclusively in the lower extremities.[22] Upon traveling to the lungs, DVT can cause medical complications including but not limited to a pulmonary embolism.[23]

The day following the Resident's admission to the Fairview TCU, the Attending Physician[24] ("Attending Physician") examined the Resident and prepared a "History and

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[13] The facility explained that, while they are related, the Hospital and the Fairview TCU are not the same corporate entity and are separately licensed. *See* comments of Surveyor and of [the Director] at the IIDR.
[14] Exs. H-1 through H-4.
[15] Exs. H-1 through H-2.
[16] Ex. H-4.
[17] Ex. H-1.
[18] [Physician Assistant E] is the Physician Assistant who provided care to the Resident while at the Fairview TCU. *See* Ex. 11.
[19] Ex. H-12; Ex. 11.
[20] Ex. H-14.
[21] Ex. I-9.
[22] Exs. I-2, I-11.
[23] Ex. I.
[24] [Physician D] is identified as the Attending Physician who served as the Resident's primary physician while admitted to the Fairview TCU. See, Fairview University Transitional Services's [sic] Memorandum in Support of IIDR, p. 6.

Physical Transitional Care Unit" ("H&P").[25] In his physical examination, the Attending Physician noted that the Resident's respiration was "[b]ilaterally clear to auscultation with no rales, rhonchi or wheezes" and that his extremities showed "[n]o cyanosis or clubbing but pitting edema in both legs."[26] In the "Assessment and Plan" portion of the H&P, [Physician D] noted, in pertinent part, as follows:

> 1. "Debilitation. Will get PT and OT consult for further care.
> ***
> 6. Deep venous thrombosis prophylaxis. We will put him on heparin 5000 units q. 12h."[27]

[Physician D] dictated the H&P on January 3, 2013, at 6:21 p.m.[28] It was transcribed on January 3, 2013 at 8:25 p.m.[29] The H&P was placed in the Resident's medical record on January 4, 2013.[30]

The IIDR record indicates that although the Attending Physician intended that the Resident would be prescribed Heparin, he did not verbally communicate that intent to the Physician Assistant[31] or to any other staff at the facility. The Physician Assistant read the H&P on January 4, 2013, and assumed that the Attending Physician would issue the necessary order.[32] Neither the Attending Physician nor the Physician Assistant ever issued a medication order for Heparin for the Resident.[33]

None of the nursing, pharmacological or other staff at the facility ever questioned the Attending Physician or the Physician Assistant about the reference to a daily dosage of Heparin in the H&P during the Resident's stay. The medical record indicates that the facility staff read and relied upon the Hospital's December 31, 2012 discharge-related h&p, and not the Attending Physician's January 3, 2013 admission-related H&P, when performing a comprehensive assessment of the Resident's status and needs on January 15, 2013.[34]

While at the Fairview TCU, the Resident received PT and OT services, sometimes in his room and sometimes elsewhere on the same floor. During these sessions he walked short distances and participated in other activities related to increasing strength, mobility, ability to transfer and to perform daily living activities.[35]

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[25] Exs. H-5 through H-7.
[26] Ex. H-6.
[27] *Id.*
[28] Ex. H-7.
[29] *Id.*
[30] Ex. E-6.
[31] Ex. H-37, footnote 1.
[32] Comments of Surveyor at IIDR.
[33] Exs. H-12 through H-27.
[34] Ex. 10, p. 2.
[35] Ex. 7; Comments of [Nurse B] at the IIDR.

As documented in the nursing notes,[36] the Resident spent much, or most, of his time at the facility seated in a recliner chair in his room. He slept in the chair, rather than in the bed, with his feet elevated but not in a full recline position.[37] He was often encouraged to ensure that his legs were elevated.[38]

Pursuant to the order issued by the Physician Assistant on January 2, 2013, the Resident was initially treated with compression boots as a guard against deep vein thrombosis. He was transitioned to the use of compression stockings, commonly known as "TED hose,"[39] by January 6, 2013 when he was noted to have "3+ pitting edema" and redness in the right lower leg upon skin inspection.[40] In response to his complaint that the TED hose were too tight and the notation that they were leaving marks on his legs, the nursing staff commenced using Ace bandages to wrap Resident's legs.[41]

On January 13, 2013, nursing staff noted that that Resident had lost 14 pounds since his admission eleven days earlier, and promptly communicated that fact to the hospitalist for evaluation.[42] The next day, the Resident felt faint upon walking from his chair to the door and was documented to be hypotensive.[43] On January 15, 2013, he reported to his OT staff that he wanted to walk to the bathroom but was unable to take a step because he did not feel strong enough.[44]

The facility completed a comprehensive Care Area Assessment ("CAA")[45] on January 15, 2013. In describing the "nature of the problem/condition" in the CAA, the facility documented "See [h&p] 12/31/12."[46] The CAA contains no reference to the H&P prepared by the Attending Physician on January 3, 2013. All portions on the CAA worksheet which requires analysis of issues related to medications are marked as not applicable.[47]

The Resident continued to decline. On January 16th, he experienced confusion to the extent that he was "unable to identify date, state, cannot draw numbers on a clock, persererating [sic] on words "apple, apple, apple" and with writing numbers on the clock (wrote 8 4x)."[48]

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[36] Ex. 9.
[37] Ex. 9, pp. 2, 3, 4, 9, 11.
[38] Ex. 9, pp. 4, 9.
[39] "TED hose" is a common name for thromboembolism-deterrent hose.
[40] Ex. 9. p. 10.
[41] Ex. 9, p. 9.
[42] Ex. 9, p. 3.
[43] *Id.*
[44] Ex. 8, p. 37.
[45] Ex. 10, titled "Fairview Health Services CAA Worksheet, is further identified as a "MDS Care Area Assessment" in Fairview TCU's Exhibit List.
[46] Ex. 10, p. 21.
[47] Ex. 10, at pp. 3 and 13.
[48] Ex. 8, p. 38.

On January 17, 2013, the Resident suffered a cardiopulmonary arrest at the facility.[49] He was transferred to the Riverside Emergency Department, where a chest CT revealed "large bilateral PEs and an echocardiogram demonstrated RV free wall akinesis with markedly elevated right-sided filling pressures."[50] He was admitted to the Hospital, where he received various treatments including "systemic TPA and system heparin for the pulmonary emboli."[51]

The Resident died on January 22, 2013.[52] His cause of death is recorded as "massive pulmonary emboli."[53]

Post-Care Analysis

The Hospital conducted a root cause analysis "with a focus on the handoff communications and medication reconciliation as it related to the discharge of [the Resident] from [the Hospital] acute care and admission to [Fairview TCU]. Providers, pharmacy staff and nursing staff from both the Hospital and Fairview TCU participated in the analysis, which identified the root cause as: "Inconsistent and variable process in how physician orders are entered into the electronic medical record increased the likelihood the medication (heparin) was omitted." The report noted that the analysis had revealed "that [the Attending Physician] had intended to have heparin ordered in addition to mechanical DVT prophylaxsis. He did [not][54] order the heparin nor did he communicate this intent to the PA."[55] Notably, the analysis ruled out the following as root or contributing causes:

> 8. Communication among staff – nursing appropriately communicated through charting with patient's compliance with DVT prophylaxis and use of a sequential compression devices and anti-embolism hose. When patient's legs became edematous, nursing appropriately got an order for ace wraps. There were communications issues identified between the Physician and the TCU Physician Assistant (PA). This is discussed below.
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> ***
>
> 14. Medication management – no issues were identified in medication management. Medications were properly stored, dispensed, and administered per existing orders. Heparin was never ordered.[56]

[49] Ex. H-29.
[50] Ex. H-35.
[51] *Id.*
[52] *Id.*
[53] Ex. H-36.
[54] The record indicates agreement that the original document's omission of "not" in this sentence represents a typographical error. *See* comments of Surveyor at IIDR.
[55] Ex. H-37.
[56] *Id.*

On March 3, 2013, the Medical Director of the Fairview TCU issued a memorandum to all relevant providers indicating that it is the responsibility of providers to place medication orders and that such action should not be "deferred to other members of the care team."[57] The facility also implemented a correction plan which included the following: the Director of Nursing met with nursing staff and educated them regarding the "good practice" of reading all resident h&ps; the facility required that all patient care be directed by a primary care provider, either a nurse practitioner or a physician assistant, whose responsibility it is to read the resident's h&p and to document in the resident's chart every issued medication order.[58]

Deficient Practices

The present matter centers on the alleged deficiencies attributed by the Department to the Fairview TCU. The parties agree that a clear error was made with respect to the Resident's care when he was not prescribed Heparin while at the Fairview TCU. On the facts in this record, it appears that the initial and primary responsibility for that error lies with the Attending Physician, who intended to have Heparin ordered but failed to write the medication order himself, and secondarily with the Physician Assistant, who reviewed the Attending Physician's H&P, noted the Attending Physician's intent to have Heparin ordered, and failed to order it or ensure it was ordered. As neither the Attending Physician nor the Physician Assistant are under the jurisdiction of the Department in this matter,[59] the deficiencies attributable to the care they provided the Resident are not presently before the Administrative Law Judge for consideration.

Tag F-224

Tag F-224 is properly issued when a compliance surveyor determines that a facility has failed to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents. Published guidance states that the facility must identify residents whose personal histories render them at risk for abusing other residents, develop intervention strategies to prevent occurrences, monitor for changes that would trigger abusive behavior, and reassess interventions on a regular basis.[60] For purposes of the regulation, "neglect" is defined as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."[61]

The state Surveyor determined that this regulation was not met in this instance because:

[57] Ex. H-39.
[58] Comments of [Director] and [Physician A] at the IIDR.
[59] The Minnesota Board of Medical Practice has jurisdiction over complaints related to allegedly substandard practices by physicians and physician assistants.
[60] Ex. F-1.
[61] Ex. F-2.

> the facility failed to ensure that policies and procedures were developed and implemented to prevent neglect of [the Resident] who required deep venous thrombosis prophylaxis;[62] and
>
> [t]he facility did not have a policy and procedure in place that addressed the review of [the R]esident's history and physicals and the clarification of pertinent information contained in the history and physicals.[63]

The Surveyor identified the following facts in support of the determinations: the Attending Physician intended that the Resident would be provided Heparin and noted this intent in the January 3, 2013 H&P; neither the Attending Physician nor the Physician Assistant wrote an order for Heparin for the Resident; neither nursing, pharmacy or other staff at the Fairview TCU noted the Attending Physician's intent to order Heparin as recorded in the H&P; the Resident developed pulmonary emboli and died as a result thereof. In essence, the Department asserts that the facility "neglected" the Resident in violation of the regulations when it failed to provide him the medical care, in the form of an order for Heparin, which was intended by the Attending Physician. Because the facility failed to have policies in place that required licensed staff to review the H&P, note any inconsistencies, and clarify the intent of the medical providers with respect to same, the Department asserted that the F-Tag 224 deficiency should be supported.

In the view of the Administrative Law Judge, the Department's reading of the regulation is overly expansive. The plain language of the full regulation, in pertinent part, provides as follows:

> (c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
>
> (1) The facility must—
>
> (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
>
> (ii) Not employ individuals who have been—
>
> (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or
>
> (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and
>
> (iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.
>
> (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown

[62] Ex. E-1.
[63] Ex. E-2.

> source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).
> (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.
> (4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.[64]

By focusing on the first sentence of the subpart and ignoring its more specific and illustrative component parts, the Department takes the position that any one incident involving a mistake in care or failure to provide a service, no matter how unintentional, constitutes prohibited "neglect." A complete reading of the regulation indicates that it requires facilities to have in place, and to follow, policies designed to protect residents from abuse, mistreatment and neglect, promptly investigate claims of such, and take appropriate action upon verification of same. The record in the present matter substantiates that Fairview TCU had appropriate policies in place.[65] The record further supports the conclusion that the facility staff followed its policies with regard to all ordered cares and medications. Heparin was not ordered; therefore it was not provided. The failure to order Heparin was a mistake made by the Attending Physician and the Physician Assistant. No policy or procedure, no matter how complete and well supported by quality training, will guarantee that every mistake will be avoided or every failure of care prevented. The fact that such a failure did occur in the present case, alone, does not support a finding that the facility violated section 483.13(c).[66]

Tag F-309

The quality of care regulations, at 42 C.F.R. § 483.25, require the facility to provide for each resident "the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, in accordance with the comprehensive assessment and plan of care." The regulation provides that "the facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process."[67] The relevant interpretive guidance instructs surveyors that, "in any instance in which there has been a lack of

[64] 42 C.F.R. § 483.13(c).
[65] *See* Exs. 1-6.
[66] *See*, in conformity, *Brian Center Health and Rehabilitation/Goldsboro v. Centers for Medicare & Medicaid Services*, DAB Civil Remedies Division No. C-08-422, Dec. No. CR2063 (February 5, 2010), Slip. Op. at 10-12 (held that one incident of failure to provide necessary service (CPR) did not substantiate F-224 deficiency).
[67] Ex. G-1.

improvement or decline, [the surveyor] must determine if the occurrence was unavoidable," which is to be found only if an "accurate and complete assessment" was completed, the care plan was consistently implemented based on the assessment, and interventions were evaluated and revised as necessary.[68] The surveyor is to "[d]etermine if the facility is providing the necessary care and services based on the findings of the comprehensive assessment and plan of care. If services and care are being provided, [the surveyor is required to] determine if the facility is evaluating the resident's outcome and changing interventions if needed."[69]

The Surveyor relies on the same set of facts in support of F-Tag 309 as set forth for F-Tag 224. Essentially, the Department asserts that the facility failed to provide the Resident with a necessary service, an order for Heparin, in accordance with the assessment and plan of care. The Admitting Physician intended that the Resident would be provided Heparin, as noted in the Assessment and Plan contained in the H&P. The Department asserts that the facility nursing staff failed to read the H&P, and therefore failed to note the inconsistency between the Attending Physician's intention and his completed orders. This failure to note the inconsistency and seek clarification from the Attending Physician constituted the alleged deficiency.

Noting that physicians differ on the advisability of prescribing anti-coagulants immediately following surgery, the facility argues that its nursing staff had no legal authority, or regulatory expectation, to "second guess" the Attending Physician's failure to prescribe Heparin upon the Resident's admission to the Fairview TCU.[70] In the face of the evidence suggesting that the facility's nursing staff was completely unaware of the intended order for Heparin, having not read the H&P, the facility asserts that there is no regulatory requirement that nurses review an H&P. The facility argues that its failure to review the H&P is not a basis for a deficiency tag.

The Administrative Law Judge disagrees. Minnesota Rules part 4658.0710 requires that a skilled nursing facility complete a history and physical ("h&p") for each resident within five days before or seven days after admission. The policy of Fairview TCU is more stringent: it requires an h&p be completed within three days of admission.[71] Implicit in these requirements that an h&p be created is the expectation that it will be read. The facility is required to complete a comprehensive assessment and plan of care for each resident. Surely, the Resident's H&P contained information relevant to a comprehensive plan of care as advised by the Attending Physician. Reasonable and expected standards of nursing practice require that licensed nurses read a patient's medical chart – the complete chart, not just the most recent portions of it – and that the nurse seek clarification of any evident inconsistencies.[72] Failing to

[68] Ex. G-2.
[69] *Id.*
[70] Comments of Surveyor at the IIDR.
[71] Comments of Sam Orbovich at IIDR.
[72] Comments of Surveyor, Christine Campbell and [Nurse B] at the IIDR. *See also*, *ManorCare at Palos Heights – West v. Centers for Medicare & Medicaid Services*, DAB Civil Remedies Division No. C-07-626, Dec. No. CR1847 (September 24, 2008), slip. op. at 11-12 (substantiating F-Tag 309 deficiency wherein facility failed to review and detect transcription error).

ensure that its staff did so, the facility was deficient in its practices and in violation of 42 C.F.R. § 483.25.

The Surveyor concluded that the deficiency caused actual harm in that the facility's failure to clarify the Attending Physician's intent to order Heparin put the Resident at high risk of developing blood clots and the Resident did in fact develop clots.[73] The Department does not assert that the Resident's death is evidence of the "actual harm" required in the "G" level of seriousness assigned to the F-309 tag in this matter. In support of its claim that, if upheld, the deficiency should be lowered to a "D" level on the CMS Grid, the facility points to the fact that the Resident may well have developed DVT even if taking Heparin and so the Department cannot establish the required "actual harm."

The State Operations Manual, Appendix P, at subp. IV.B.3, provides as follows:[74]

> Level 3 is noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequence to the resident.

The Department demonstrated that the Resident suffered a negative outcome that compromised his ability to reach his highest practicable physical well-being as defined by the Attending Physician's plan of care, as recorded in the H&P. Given his sedentary level of activity, edema, low blood pressure and overall debilitated state, he was placed at a higher risk for developing clots and did in fact develop clots because he was not given a reasonable and necessary service relevant to the prevention of DVT, as intended. As this was, fortunately, an isolated incident, the scope and severity represented in the CMS Grid at category "G" is appropriate for this substantiated deficiency.

T. L. P.

[73] Comments of Kristine Luhrke at the IIDR.
[74] Ex. C.